MedicAide
An informational newsletter for Medicaid Providers

From the Idaho Department of Health and Welfare, Division of Medicaid June 2003

In this issue:

Distributed by the Division of Medicaid Department of Health and Welfare State of Idaho

Idaho Medicaid and Diabetes

Diabetes Disease Management

The new look of Medicaid includes diabetes disease management measures with a focus on quality outcomes and cost effectiveness. It is estimated that Idaho may be spending almost 70 million dollars annually on diabetes care, based on the number of Medicaid clients with diabetes (5,258) multiplied by $13,243 per capita medical expenditure per person with diabetes for the year 2002 (Source: Economic Costs of Diabetes in the U. S. in 2002, American Diabetes Association. Diabetes Care 26:917-932, 2003).

Currently, Idaho Medicaid provides case management services for medically complex and/or high cost clients who have diabetes and who have been referred to the Care Management Bureau.

In addition, Idaho Medicaid supports providers who are managing diabetes care by providing diabetes education patient materials. In cooperation with the Diabetes Alliance of Idaho, the "Take Charge of Your Diabetes" patient booklets are being distributed to providers for use in their patient education efforts. Also, Medicaid is collaborating to develop and distribute smoking/diabetes patient education materials.

In order to address the problem of inappropriate use of insulin pumps among Medicaid clients, Idaho Medicaid is currently revising prior authorization criteria for insulin pump use.

Contact: Linda Schrock (208) 364-1818

Diabetes Counseling/Education Training

Idaho Medicaid covers diabetes education and training services when provided in a hospital outpatient setting or a physician's office. Only a Certified Diabetes Educator (CDE) may provide the education and training services using a formal diabetes management program recognized as meeting the program standards of the American Diabetes Association. The patient must meet the medical necessity criteria in IDAPA rule at 16.03.09.128.

A One Time Provider Review is Initially Required in order to Provide Diabetes Counseling/Education Training:

Physicians or hospitals must request to provide this service prior to service provision. Send or fax the following information to Cindy Taylor at P.O. Box 83720; Boise, Idaho 83720; fax number (208) 364-1911. Please include:

- Your current Idaho Medicaid provider number used to bill the service
- Whether you will be providing individual and/or group counseling/education
- A current copy of the diabetic educator's certificate

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Idaho Medicaid and Diabetes

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Billing for Diabetes Counseling/Education Training:

1. *Physicians' Offices:* A physician's office setting must bill using procedure code G0108 for **individual** counseling/education. The CDE's services are to augment and not be substituted for the services a physician is expected to provide. Medicaid allows 12 individual hours per client every five (5) calendar years payable at $53.77 per hour (one unit equals thirty (30) minutes). Procedure code G0109 is to be used for **group** training. Medicaid allows twenty-four (24) hours of group sessions every five (5) calendar years payable at $10.25 per hour (one unit equals thirty (30) minutes). Prior authorization is not required to provide services to individuals.
2. *Outpatient Hospital Settings:* When the service is provided in an outpatient hospital setting, the procedure codes identified in the prior paragraph must be billed in conjunction with revenue code 942. Prior authorization is not required to provide services to individuals.

Rules governing the Medical Assistance Program are in Idaho Administrative Code, IDAPA 16.03.09, accessible on the web at www.idahohealth.org and www.accessidaho.org.

Contact: Jan Uren (208) 364-1854

EPSDT Additional Diabetes Counseling/Education Training Hours for Children:
If additional diabetes counseling/education training hours are medically necessary for clients under the age of 21, a prior authorization request may be submitted to the EPSDT Program, Dee Patterson, at P.O. Box 83720; Boise, Idaho 83720; fax number (208) 364-1864. Please include:

- Client name and Medicaid ID #
- Statement of medical necessity by physician
- Number of additional units requested
- Doctor's signature

Contact for EPSDT: Dee Patterson (208) 364-1842

Medications for Diabetes
Antidiabetic medications are a Medicaid benefit and do not require prior authorization.

Current Medicaid Pharmacy activities surrounding diabetes care include:

1. Education to Medicaid prescribers who have been identified as having one or more diabetic patients who are not receiving an ACE (angiotensin converting enzyme) inhibitor drug or an ARB (angiotensin receptor blocker) drug. Both drugs have protective cardiovascular effects in people with diabetes.
2. Education letters to Medicaid prescribers or pharmacies when a potential drug therapy problem is identified for a Medicaid client. These identified problems include: patients with potential drug-drug interactions; patients at increased risk of adverse drug events; and patients on duplicate antidiabetic medications in the same drug class.

Contact: Tami Eide 208-364-1821

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DHW Phone Numbers Addresses Web Sites

DHW Websites:
www.idahohealth.org
www2.state.id.us/dhw
www2.state.id.us/dhw/medicaid/providers/pharmacy.htm

DHW Customer Service
(800) 378-3385
(208) 334-5795

Idaho Careline
211 (not available in all areas)
(800) 926-2588

Provider Fraud and Utilization Review
P. O. Box 83720
Boise, ID 83720-0036
(866) 635-7515 (toll free)
(208) 334-0675
Email:
~medicaidfraud&sur@idhw.state.id.us
(note: begins with ~)
Internet:
www2.state.id.us/dhw/Medicaid/providers/fraud.htm

Healthy Connections
Region I - Coeur d'Alene
(208) 666-6766
(800) 299-6766

Region II - Lewiston
(208) 799-5088
(800) 799-5088

Region III - Caldwell
(208) 455-7280
(800) 494-4133

Region IV - Boise
(208) 334-4676
(800) 354-2574

Region V - Twin Falls
(208) 736-4793
(800) 897-4929

Region VI - Pocatello
(208) 239-6260
(800) 284-7857

Region VII - Idaho Falls
(208) 528-5786
(800) 919-9945

Spanish Speaking
(800) 862-2147

Statewide
Americana Terrace
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5795
(800) 378-3385

Prior Authorization Phone Numbers Addresses Web Sites

DME Prior Authorizations
DME Specialist
DHW Bureau of Medicaid Programs
PO Box 83720
Boise, ID 83720-0036
(866) 205-7403 (toll free)
Fax
(800) 352-6044
(att: DME Specialist)

EMS Review Unit
(800) 362-7648
(208) 334-2484
Fax
(800) 359-2236
(208) 334-5242

PCG
P.O. Box 2894
Boise, ID 83701
(800) 873-5875
(208) 375-1132
Fax (208) 375-1134

Pharmacy
P.O. Box 83720
Boise, ID 83720-0036
(877) 200-5441 (toll free)
(208) 364-1829
Fax (208) 364-1864
Web: www2.state.id.us/dhw/medicaid/providers/pharmacy.htm

Qualis Health (telephonic & retrospective reviews)
10700 Meridian Ave. N.
Suite 100
Seattle, WA 98133-9075
(800) 783-9207
Fax (800) 826-3836 or
(206) 368-2765

Qualis Health Website
www.qualishealth.org/idahomedicaid.htm

Transportation Prior Authorization Unit
(800) 296-0509
(208) 334-4990
Fax
(800) 296-0513
(208) 334-4979

Idaho Medicaid and Diabetes

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Durable Medical Equipment (DME) for Diabetes Care

DME program guidelines allow for most diabetes supplies **without** prior authorization. The physician writes a prescription, which must include the medical necessity, specific supplies ordered, the quantities/frequency of use, and the length of need. The following diabetes supplies do not require prior authorization:

- Alcohol swabs
- Batteries for blood glucose monitor
- Blood glucose monitor
- Blood glucose test strips
- Lancets
- Lancet device, spring powered
- Shoe inserts
- Syringes
- Urine glucose/ketone test strips

The following **require** prior authorization:

- Insulin pump
- Insulin pump supplies

The insulin pump equipment provider may submit a completed prior authorization request form (available from DME) to the DME program at fax number (800) 352-6044. Please include:

1. A physician's prescription which includes medical necessity, equipment and supplies required, and the length of need
2. Documentation from the past 6 months of the patient's blood glucose readings, insulin dose adjustments, carbohydrate counts, HbA1c levels, and physician progress notes
3. C-Peptide level

Contact: DME Specialist (866) 205-7403 (toll free) or (208) 364-1914

Submitted by DHW

PES (Provider Electronic Solutions) Assistance

By now you should have received a CD containing the new Provider Electronic Solutions (PES) software. PES replaces the current Idaho Medicaid/EDS software ECMS-PC. You can use PES to verify eligibility and service limitations. PES can also be used to submit HIPAA-formatted professional, dental, institutional and retail pharmacy claims.

We encourage you to use the PES handbook that is included on the CD with the software. The handbook provides step-by-step instructions for using PES. PES also includes built-in help files. You can access "Help' from the main menu. "Help' can also be accessed from many fields by placing your cursor in the field and pressing "F1" or selecting the command button titled "Help". If you cannot find the answer you need in the PES handbook or in the "Help" files, phone MAVIS at (800) 685-3757 or (208) 383-4310 local Boise area. Say the word "AGENT" and your call will be routed to a Provider Service Representative for assistance.

Submitted by DHW HIPAA Project

Updated Provider Handbook

The Idaho Medicaid Provider Handbook was updated in April 2003. The handbook is accessible from the sources listed below. Please note that the most current handbook is always available on the Division of Medicaid website.

- Idaho Division of Medicaid website link: http://www2.state.id.us/dhw/medicaid/provhb/index.htm
- CD mailed to providers in April that includes the *Idaho Medicaid Provider Handbook*, PES handbook, PES software, *What is Medicaid?*, and Acrobat Reader®

Submitted by DHW HIPAA Project

Updated HIPAA Website for Providers and Vendors
http://www2.state.id.us/dhw/hipaa/index.htm

The HIPAA Website has been updated with information about events that will impact you directly, beginning in May of 2003. Idaho Medicaid is implementing changes to comply with HIPAA legislation that affects processes you use for checking eligibility and submitting claims.

Web technology provides an efficient means for keeping you updated with timely information. In addition to adding new information, we've restructured the information, making it easier for you to find items that relate to you specifically. The site will be updated on a routine basis with changing or new information. Please visit the site and forward any comments and suggestions to our email address: HIPAAComm@idhw.state.id.us.

Providers…Answers to Your Frequently Asked Questions About HIPAA!
The Department's HIPAA Website contains a Frequently Asked Question (FAQ) section you will want to visit routinely because the FAQs will be updated frequently. If you do not have internet access, you may request a printed copy of the FAQs by calling MAVIS at (800) 685-3757 or (208) 383-4310 in the local Boise area. Say the word "AGENT" to speak to a Provider Service Representative and request the HIPAA FAQs.
Current FAQs relate to:

- HIPAA Transaction and Code Set compliance.
- Pharmacy: new HIPAA electronic pharmacy transaction.
- Pharmacy: changes related to collecting other insurance information.
- Provider Electronic Solutions (PES) software, which is the new Idaho Medicaid/EDS software used for verifying eligibility and service limitations, and for submitting HIPAA-formatted professional, dental, institutional and retail pharmacy claims.

For example, PES questions relate to loading the software, password and submitter ID, verifying eligibility, submitting claims, entering and using lists, and taxonomy codes, to name a few. The PES Handbook is on the CD you received that contains the software application and is your primary source for detailed information about using PES.

Make the HIPAA Website a favorite in your Website links: http://www2.state.id.us/dhw/hipaa/index.htm

The Department's HIPAA Website is sponsored by Idaho Medicaid and the HIPAA Project Team.

Submitted by DHW HIPAA Project

Use New Provider Enrollment Applications

Providers are reminded that they should use current provider enrollment applications when enrolling new members of a group practice. The applications were recently revised. The easiest way to determine if you are using a new application is to look at the W-9 form. If it has only two pages, you have an old application. Please discard any old applications. To request a new application, call MAVIS and say *AGENT* immediately after the MAVIS greeting.

Provider Enrollment Fax Number
When faxing documentation (including license and certification) to EDS Provider Enrollment, please use their dedicated fax number:

(208) 395-2198

Submitted by EDS

EDS Phone Numbers Addresses

MAVIS
(800) 685-3757
(208) 383-4310

EDS Correspondence
PO Box 23
Boise, ID 83707
Provider Enrollment
P.O. Box 23
Boise, Idaho 83707
Medicaid Claims
PO Box 23
Boise, ID 83707
PCS & ResHab Claims
PO Box 83755
Boise, ID 83707

EDS Provider Fax
(208) 395-2198

Client Assistance Line
Toll free: (888) 239-8463

H I P A A

DHW HIPAA Project

Mail:
DHW HIPAA Project
DHW
PO Box 83720
Boise, ID 83720-0036

Email:
HIPAAComm@idhw.state.id.us

Fax:
DHW HIPAA Project
(208) 334-0645

Internet:
www.idahohealth.org
(select H&W HIPAA quicklink)
or
www2.state.id.us/dhw/hipaa/index.htm

Software Testing:
(866) 301-7751

EDS Phone Numbers Addresses

Provider Relations Consultants

Region 1
Prudie Teal
1120 Ironwood Dr., # 102
Coeur d'Alene, ID 83814

prudie.teal@eds.com
(208) 666-6859
(866) 899-2512 (toll free)
Fax (208) 666-6856

Region 2
JoAnn Woodland
1118 F Street
P.O. Drawer B
Lewiston, ID 83501

joann.woodland@eds.com
(208) 799-4350
Fax (208) 799-5167

Region 3
Mary Jeffries
3402 Franklin
Caldwell, ID 83605

mary.jeffries@eds.com
(208) 455-7162
Fax (208) 454-7625

Region 4
Jane Hoover
1720 Westgate Drive, # A
Boise, ID 83704

jane.hoover@eds.com
(208) 334-0842
Fax (208) 334-0953

Region 5
Penny Schell
2241 Overland Avenue
Burley ID 83318

penny.schell@eds.com
Burley: Tuesday & Friday
(208) 677-4002

Twin Falls: Mon, Wed, Thurs
(208) 736-2143
Fax (208) 678-1263

Region 6
Sheila Lux
1070 Hiline Road
Pocatello, ID 83201

sheila.lux@eds.com
1-208-239-6268
Fax 1-208-239-6269

Region 7
Bobbi Woodhouse
150 Shoup Avenue
Idaho Falls, ID 83402

bobbi.woodhouse@eds.com
(208) 528-5728
Fax (208) 528-5756

Prescription Splitting

Some pharmacies have a practice of "prescription splitting" that is becoming more of a problem. In an attempt to help control the rising cost of prescriptions, the Medicaid Pharmacy Unit is addressing maximum monthly quantity limits.

You may have noticed recently that some prescriptions for quantities over the maximum monthly quantities that previously were paid are being rejected. To get around this, pharmacies are splitting the prescribed 30 day supply and dispensing a 15 day supply every 15 days. This is "Prescription Splitting" and is considered fraudulent because the pharmacy receives duplicative dispensing fees.

For example, omeprazole 20 mg is indicated for once daily (except *H. pylori*). When a pharmacy receives a prescription for twice daily omeprazole and receives a reject message for 60 capsules for 30 days then dispenses 30 capsules every 15 days, that pharmacy is committing fraud. The proper action is to initiate a quantity override and bill on paper if and when the request is approved.

The Provider Handbook 3.6.6.1 states, *"The pharmacist must justify multiple dispensing of maintenance medications and "prescription splitting" and document the reason on the paper copy of the prescription. This must be a sound medical reason and not just for the convenience of the client, facility, or pharmacy. Medicaid determines the validity of such rationale."* This rule assures the State pays only one dispensing fee per month for maintenance medications and increases patient convenience. Prescribers request the higher dose with documentation supporting the use on a "Quantity Override" form available on our Website (www.idahohealth.org) or from the pharmacy program. If approved, the pharmacy must bill on paper for proper reimbursement.

Multiple dispensing (prescription splitting) is allowed "if the quantity needed for a 30-day supply is excessively large or unduly expensive, in the judgment of Medicaid." If the pharmacy feels multiple dispensing is justified, appropriate documentation is the best way to avoid recoupment from auditors. If in doubt, contact the pharmacy department (208-364-1829) for clarification.

Submitted by DHW

Dental Providers: Correction and additional information regarding the Adult Emergency Dental Program

The list of codes for the Adult Emergency Dental Program should also include CDT-4 **D2150** *Amalgam, two surfaces, primary or permanent.*

Information Release 2003-22 describes the current policy for the Medicaid Dental Program. Information Release MA02-33 is no longer in effect. Claims for adult emergency **and adult high risk** services can be submitted without additional documentation attached to the claim form. Only those codes listed in Information Release 2003-22 for adult emergency services or services for high-risk adults are a covered benefit of the Adult Dental Program.

Submitted by DHW

New MAVIS Feature for EDI Questions

Providers can now go directly to the EDI Technical Support helpdesk with their questions. The helpdesk can answer questions about transmission errors, batch inquiries, software issues, troubleshooting, and vendor testing. Call MAVIS and say *TECHNICAL SUPPORT* immediately after the MAVIS greeting.

Submitted by EDS

Using the Idaho Medicaid CD

There are several resources available on the Idaho Medicaid CD providers recently received. It contains:

- Provider Electronic Solutions (PES), the new eligibility and billing software
- *Idaho PES Handbook*, a user manual with complete instructions on how to install and use PES
- *Idaho Medicaid Provider Handbook*, including instructions for all Idaho Medicaid provider types
- *What is Medicaid?*, the client handbook in both English and Spanish
- *Qualis Health Provider Handbook*, a handbook for Qualis Health prior authorizations
- Acrobat Reader®, used to open the handbooks

The user may print any of the handbooks or copy them onto a desktop computer or LAN. To print or copy the handbooks, follow these instructions:

Step 1 Place the CD in your computer CD-ROM drive. A window will open and display the CD contents. Select CLOSE.

Step 2 Open Windows Explorer.

Step 3 Double-click to select your CD-ROM drive (usually the D drive). This will open a list of all the folders on the CD.

Step 4 Double-click to select the folder you want. This will open a list of all the files in that folder.

Step 5 Right-click and select the file you want to print or copy. Left-click to select PRINT or COPY from the dropdown menu.

Step 6 If you are making a copy on your hard drive, select the folder on your hard drive where you want to save the file. Left-click and select PASTE.

To build a copy of *the Idaho Medicaid Provider Handbook* select from the following files in the folder called Provider_Handbook:

1a_cover.pdf	Cover page and letter from the interim administrator
1a_directory.pdf	Directory of phone numbers and addresses, and cover pages for newsletters, information releases, and fee schedules
s1_gen_info.pdf	Section 1 contains general provider and client information for all providers
s2_gen_billing.pdf	Section 2 contains general billing information for all providers
s3_provider_type.pdf	There is a Section 3 file for each provider type including a Healthy Connections supplement. These files contain specific billing information for each provider type. Select the file for your provider type.
s4_ra_****.pdf	There is a Section 4 file for specific information on each type of remittance advice. prof = professional; inst = inst; and phar = pharmacy. Select the file for your remittance type.
s5_glossary.pdf	Section 5 is a glossary of terms used in the handbook.

There are two appendices:

s6a_forms.pdf	The forms appendix includes forms that can be copied for use as needed and a list of forms that can be ordered from EDS.
s6a_mavis.pdf	The MAVIS appendix includes complete instructions for MAVIS, the Medicaid Automated Voice Information Service.

Please Note: The *Qualis Health Provider Handbook* and a second copy of *What Is Medicaid?* in Spanish and English are also in the Provider_Handbook folder. These files are named:

qualis.pdf	*Qualis Health Provider Handbook*
DHW_what_is_medicaid.pdf	*What Is Medicaid?* (English)
what_is_medicaid_spanish.pdf	*What Is Medicaid?* (Spanish)

Submitted by EDS

Information Releases Table of Contents

Information Releases on Web

To obtain a copy of any current information release, please check the DHW website at **www2.state.id.us/dhw** and select **Medicaid**. If you do not have access to the Internet or do not see the specific release listed and would like a copy, please call (208) 334-5795.

April 7, 2003

MEDICAID INFORMATION RELEASE #2003-08

TO: INDIAN HEALTH CLINICS

FROM: Paul Swatsenbarg, Deputy Administrator, Division of Medicaid

SUBJECT: ENCOUNTER CODES

Due to the requirements of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), transactions and code sets must be consistent nationally. Idaho has been using unique codes to report, reimburse for and describe services that are not found in any national coding systems. Therefore, Idaho Medicaid has to conform to the requirements of HIPAA and use nationally accepted codes.

Effective for dates of service on or after 6/1/03, procedure code 5999I, Health Encounter, will be obsolete. It will be replaced by the following Healthcare Common Procedure Coding System (HCPCS) codes:

- T1015 Clinic Visit/Encounter, all inclusive
- D2999 Dental Visit/Encounter

The reimbursement amount for the above encounters will not change. If you have any questions please contact Sheila Pugatch at (208) 364-1817.

PS/rc/ea

April 1, 2003

MEDICAID INFORMATION RELEASE 2003-17

TO: AMBULANCE SERVICE PROVIDERS - EMERGENCY AND NON-EMERGENCY

FROM: Paul Swatsenbarg, Deputy Administrator, Division of Medicaid

SUBJECT: NON-HOSPITAL BASED GROUND AMBULANCE REIMBURSEMENT METHODOLOGY

Idaho Medicaid is changing the current ground ambulance reimbursement methodology and rates to align more closely with Medicare's bundled reimbursement rates for **non-hospital based** ground ambulance services.

The following changes to ground ambulance reimbursement are effective for dates-of-service on or after **April 1, 2003**.

- Supplies and medications will be included within the bundled rates and will no longer be covered as separately billable services/items.
- New codes recognize three levels of life support: Basic and two levels of Advanced Life Support (BLS, ALS I and ALS II). These levels are further categorized into non-emergency and emergency levels of services.
- Although Medicare reimburses ground mileage at three different levels (urban, rural, and mileage 18 through 50), Idaho Medicaid will reimburse mileage at a flat rate of $4.24 per loaded mile.

HCPCS	Description	Reimburse-ment
A0420	Ambulance Waiting time (ALS or BLS), one-half hour increments	$4.42
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); requires medical review	$145.21
A0425	Ground mileage, per statute mile	$4.24
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)	$102.50
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1-emergency)	$162.30
A0428	Ambulance service, basic life support, non-emergency transport (BLS)	$85.42
A0429	Ambulance service, basic life support, emergency transport (BLS-emergency)	$136.67
A0433	Advanced life support, level 2 (ALS 2) Treat and Release (Ambulance response and treatment, no transport)	$234.91
T2006	Requires Prior Authorization and documentation of services provided. Reimbursement will be based on type and complexity of services provided. • Respond and Evaluate, no other services (all levels) • Response and Treatment, BLS • Response and Treatment, ALS	 $85.42 $136.67 $162.30

For prior authorization of non-emergency transports and retrospective review of emergency ambulance services, please contact the EMS Bureau, Review Unit at

(208) 334-2484 or toll-free (800) 362-7648. If you have questions regarding the information in this notice, please contact Colleen Osborn (208) 364-1923. Thank you for your continued participation in the Idaho Medicaid Program.

March 14, 2003

MEDICAID INFORMATION RELEASE 2003-18

TO: ALL NURSING HOME and ICF/MR ADMINISTRATORS

FROM: Paul Swatsenbarg, Deputy Administrator, Division of Medicaid

SUBJECT: INFORMATION REQUEST RELATED TO PCS WAGE DETERMINATION

Each year, the Department gathers information from all Nursing Facilities (including hospital-based facilities) and Intermediate Care Facilities for the Mentally Retarded in order to determine wage data for select employees within the nursing home industry.***** At this time, the Department is requiring that facilities respond according to the attached instructions and complete the attached certification. A survey form is also being provided to assist you in the completion of this request.

If your facility was certified for participation in the Medicaid program before March 15, 2003, you must respond by April 18, 2003. Otherwise, you are not required to participate this year. Please return the requested information as soon as possible to:

Myers and Stauffer LC

8555 West Hackamore Drive, Suite 100

Boise, ID 83709

If you have questions, please feel free to contact Sheila Pugatch at (208) 364-1817 or Myers and Stauffer at (800) 336-7721. Thank you for your participation in Idaho Medicaid.

LC/vcc/ss

Attachments
(attachments available on the DHW Website: www2.state.id.us/dhw/medicaid/inf/2003/03med18.htm)

***** Per Idaho Code, Section 39-5606, and IDAPA 16.03.10.202.03

March 15, 2003

MEDICAID INFORMATION RELEASE 2003-19

TO: HOSPITAL ADMINISTRATORS

FROM: Paul Swatsenbarg, Deputy Administrator, Division Of Medicaid

SUBJECT: NOTICE OF 2003 MEDICAID RATES FOR SWING-BED DAYS AND ADMINISTRATIVELY NECESSARY DAYS (AND)

Effective for dates-of-service **on or after January 1, 2003**, Medicaid will pay the following rates:

Swing-Bed Day	$165.86
Administratively Necessary Day (AND)	$136.60

If you have already billed for swing-beds days since 01/01/03, please submit corrected claim adjustments to EDS in order to receive reimbursement with the new rate listed above.

If you have any questions concerning the information contained in this release, please contact Sheila Pugatch, Senior Financial Specialist for the Bureau of Medicaid Benefits and Reimbursement Policy, at (208) 364-1817.

Thank you for your continued participation in the Idaho Medicaid Program.

PS/sp/co

April 29, 2003

MEDICAID INFORMATION RELEASE 2003-22

TO: DENTAL PROVIDERS

FROM: Paul Swatsenbarg, Deputy Administrator

SUBJECT: CHILDREN'S DENTAL PROGRAM
PREGNANT WOMEN AND CHILDREN (PWC) PROGRAM
ADULT EMERGENCY DENTAL PROGRAM
SERVICES FOR HIGH-RISK ADULTS
PRIOR AUTHORIZATION
BILLING CHANGES FOR CODE D0460

The Department is now utilizing the 2003 CDT-4 procedure codes. The codes are effective for dates-of-service on or after January 1, 2003. Any CDT-4 code not listed in this information release or in the handbook is not a covered benefit of the dental program. Attached is the updated Medicaid fee schedule. If you have claims with dates of service on or after January 1, 2003, which were paid at a different reimbursement than the new list indicates, please submit an adjustment request form to EDS for additional payment.

At this time, Medicaid cannot process claims submitted on the 2003 American Dental Association (ADA) claim form because it does not contain all the required fields needed for processing. When submitting paper claims, please use the 1999 (2000) ADA claim form for faster processing. Medicaid will accept claims submitted on ADA dental claim forms older than the ADA 1999 (2000), but please be aware that claims submitted on older ADA claim forms will require a longer period to process.

New CDT-4 procedure codes for oral and maxillofacial surgeries are not covered under Medicaid's dental program. However, the equivalent CPT codes, which were covered prior to January 1, 2003, are still covered when billed on a CMS-1500 claim form as a medical claim.

Providers will receive the updated Dental Guidelines Provider Handbook in April. Please be aware that changes to the Adult Dental Program and the children's orthodontic program were made after the revised dental provider handbook was sent to print. Program updates are sent to providers via information releases and they will supercede information contained in the handbook.

Children's Dental Program

Diagnostic Services								
D0120	D0150	D0170	D0220	D0240	D0272	D0277	D0340	D0470
D0140	D0160	D0210	D0230	D0270	D0274	D0330	D0460	D0999
Preventive Services								
D1110	D1203 (up to age 21)			D1351	D1515	D1525		
D1120	D1204 (age 21 and older)			D1510	D1520	D1550		
Restorative Services								
D2140	D2330	D2390	D2394	D2751	D2792	D2932	D2954	
D2150	D2331	D2391	D2710	D2752	D2920	D2940	D2955	
D2160	D2332	D2392	D2721	D2790	D2930	D2950	D2980	
D2161	D2335	D2393	D2750	D2791	D2931	D2951	D2999	
Endodontic Services								
D3110	D3221	D3320	D3346	D3348	D3421	D3426	D3999	
D3220	D3310	D3330	D3347	D3410	D3425	D3430		
Periodontic Services								
D4210	D4320	D4341	D4355	D4999				
D4211	D4321	D4342	D4910					

Prosthodontic Services								
D5110	D5212	D5421	D5620	D5670	D5741	D5850	D6980	
D5120	D5213	D5422	D5630	D5671	D5750	D5851	D6999	
D5130	D5214	D5510	D5640	D5730	D5751	D5899		
D5140	D5410	D5520	D5650	D5731	D5760	0515D		
D5211	D5411	D5610	D5660	D5740	D5761	D6930		
Prosthetic Services								
D5931	D5934	D5951	D5954	D5959	D5988			
D5932	D5935	D5952	D5955	D5960	D5999			
D5933	D5936	D5953	D5958	D5982				
Oral Surgery								
D7111	D7220	D7241	D7280	D7287	D7510	D7970		
D7140	D7230	D7250	D7281	D7320	D7910	D7971		
D7210	D7240	D7270	D7286	D7471	D7960	D7999		
Orthodontic Services **Effective for dates-of-service on or after May 1, 2003, Interceptive Orthodontics, procedure codes D8050 and D8060, are no longer a covered benefit of the Children's Dental Program.**								
D8010	D8030	D8070	D8090	D8220	D8680	D8999		
D8020	D8040	D8080	D8210	D8670	D8691			
Adjunctive General Services								
D9110	D9230	D9310	D9430	D9930	D9952			
D9220	D9241	D9410	D9440	D9940	D9999			
D9221	D9242	D9420	D9920	D9951				

Pregnant Women and Children Dental Program (PWC)

The following are the only codes covered for women on the PWC program. For more information on the PWC program, please refer to your provider handbook, Section One; General Provider and Client Information.

D0140	D0330	D4341	D7111	D7220	D7510	D9420	D9930
D0220	D2940	D4342	D7140	D7230	D9110	D9430	
D0230	D3220	D4355	D7210	D7250	D9310	D9440	

Adult Emergency Dental Program

Idaho Medicaid's adult dental program covers emergency services and services for high-risk clients only. The following dental codes are covered for adults after the month of their twenty-first (21) birthday who are in need of emergency dental treatment or who are considered high-risk adults. Claims for these services can be submitted without additional documentation attached to the claim form. It is required that the patient's record must include documentation indicating an emergency dental situation existed at the time of service or the client, in the professional opinion of the dentist, using the prevailing standards within the dental community, meets the criteria for a high-risk adult.

Denturist services listed in Section 906, Rules Governing the Medical Assistance Program, may be provided by a denturist when the client has a referral and documentation from a dentist stating that a dental emergency exists or the client meets the criteria for a high-risk adult. Medicaid Dental Consultants suggest the following parameters, although not all-inclusive, to help guide providers in determining:

1. when a client is in need of emergency services
2. when a client should be considered "high-risk"

Emergency Services for Adults

Adults (defined for these purposes as persons who are past the month of their twenty-first (21) birthday) without eligibility restrictions are covered by Medicaid for certain emergency services. *

- Emergency services can be interpreted as treatment necessitated by an unforeseen, sudden, or acute onset of symptoms or injuries requiring immediate treatment, where delay in treatment could jeopardize or cause permanent damage to a person's oral or medical health.
- Every patient "complaint" does not meet the above criteria for an emergency service, and therefore would not be covered by Medicaid. For example, chronic conditions without sudden, acute symptoms are not covered. The provider should review the patient's needs with this understanding in mind.

Services for High-Risk Adults

- High-risk adults are those who are in need of dental intervention because infection or advanced treatment represents a significant risk to their physical health.
- High-risk adult patients include persons who would be at considerable risk for rapidly advancing dental disease and significantly increased emergency or acute care if these preventive and minor restorative dental services are withheld.
- High-risk adult patients also include persons with tooth or periodontal conditions who are at high risk for periodontal infection likely to lead to bacteremia or other serious health concerns.
- Examples of conditions which may place a patient at high risk may include, but are not limited to:
    - Pre-and post-organ transplants
    - Prosthetic joints or heart valve
    - Radiation or chemotherapy
    - Indwelling shunts for dialysis or hydrocephaly
    - Advance HIV/AIDS or other immunosuppressive conditions
    - Xerostomia
    - Diabetes
    - Autoimmune disorders such as rheumatoid arthritis or lupus
    - Physically handicapped or developmentally disabled
    - Other medical or mental conditions, such as Severe and Persistent Mental Illness (SPMI), which prevent the person from performing their own oral care and who do not have a caregiver to assist them with oral care.

* See *Rules Governing the Medical Assistance Program*, Section 915, which can be found at: http://www2.state.id.us/adm/adminrules/rules/adapa16/0309.pdf

D0120	D0277	D2332	D2940	D5130	D5520	D5730	D7140	D7510	D9242
D0140	D0330	D2335	D3220	D5140	D5610	D5731	D7210	D7910	D9310
D0150	D1110	D2390	D3221	D5211	D5620	D5740	D7220	D7970	D9410
D0210	D1204	D2391	D4341	D5212	D5630	D5741	D7230	D7971	D9420
D0220	D2140	D2392	D4342	D5410	D5640	D5750	D7240	D9110	D9440
D0230	D2160	D2393	D4355	D5411	D5650	D5751	D7241	D9220	D9930
D0270	D2161	D2394	D4910	D5421	D5660	D5760	D7250	D9221	
D0272	D2330	D2920	D5110	D5422	D5670	D5761	D7286	D9230	
D0274	D2331	D2931	D5120	D5510	D5671	D7111	D7287	D9241	

Prior Authorization

All procedures that require prior authorization must be approved prior to the service being rendered. Prior Authorization requires written submission including diagnostics. Retroactive authorization will be given only in an emergency situation or as the result of retroactive eligibility. Prior authorization of Medicaid dental procedures does not guarantee payment. The client's Medicaid eligibility must be verified by the provider before the authorized service is rendered. Please send all prior authorization requests to the following address: Idaho Medicaid, Attn: Medicaid Dental Consultants, P.O. Box 83720, Boise ID, 83720-0036. If you have questions regarding prior authorizations, please contact Bonnie (208) 364-1839.

Billing Changes for D0460

D0460 *Pulp vitality test, includes multiple teeth and contralateral comparison(s), as indicated*. When submitting a claim with D0460, providers will no longer be required to report a tooth designation. This procedure will be allowed only once per day, per client.

If you have questions regarding the information in this notice, please contact Colleen Osborn (208) 364-1923. Thank you for your continued participation in the Idaho Medicaid Program.

PS/af/co

STATE OF IDAHO MEDICAID DENTAL FEE SCHEDULE
effective January 1, 2003
Covered procedure codes & fees are subject to change.
Consult your Dental Guidelines Manual for limitations.

Procedure Code	Description	2003 Fee Schedule
0515D	Unable to deliver dentures	MP
D0120	Periodic oral evaluation & periodont. screening	$ 17.00
D0140	Limited oral eval.–specific oral health problem	$ 24.00
D0150	Comprehensive oral eval. with recording of tissues	$ 25.00
D0160	Detailed/extensive oral eval	$ 37.00
D0170	Re-evaluation, limited, focused	$ 24.00
D0210	Intraoral-complete series	$ 53.00
D0220	Intraoral-periapical- first	$ 9.00
D0230	Intraoral periapical – each	$ 8.00
D0240	Intraoral occlusal film	$ 10.00
D0270	Bitewing single film	$ 9.00
D0272	Bitewings - two films	$ 16.00
D0274	Bitewings - four films	$ 24.00
D0277	Vertical bitewings – 7 to 8 films	$ 56.00
D0330	Panoramic film	$ 40.00
D0340	Cephalometric film	$ 43.00
D0460	Pulp vitality tests	$ 15.00
D0470	Diagnostic casts	$ 38.00
D0999	Unspecified diag procedure,	MP
D1110	Prophylaxis – adult, includes polishing	$ 40.00
D1120	Prophylaxis – child	$ 28.00
D1203	Topical appl of fluoride child	$ 13.00
D1204	Topical appl of fluoride adult	$ 16.00
D1351	Sealant	$ 20.00
D1510	Fixed - unilateral - space maint.	$ 104.00
D1515	Fixed - bilateral - space maint.	$ 132.00
D1520	Removable unilateral space maint.	$ 77.00
D1525	Removable bilateral space maint.	$ 142.00
D1550	Recementation of space maint.	$ 20.00
D2140	Amalgam - one surface primary permanent	$ 35.00 $ 42.00
D2150	Amalgam - two surfaces primary permanent	$ 46.00 $ 55.00
D2160	Amalgam - three surfaces primary permanent	$ 54.00 $ 65.00
D2161	Amalgam four + surfaces primary permanent	$ 60.00 $ 77.00
D2330	Resin – one surface anterior	$ 50.00
D2331	Resin – two surface anterior	$ 65.00
D2332	Resin - three surface anterior	$ 79.00

D2335	Resin - four + surfaces anterior	$ 92.00
D2390	Resin based comp crown, anterior, permanent only	$ 95.00
D2391	Resin-based comp - 1 surface, posterior – primary (not preventative) permanent	$ 39.00 $ 53.00
D2392	Resin based composite – 2 surf., posterior – primary permanent	$ 54.00 $ 68.00
D2393	Resin based composite – 3 surf., posterior - primary permanent	$ 66.00 $ 87.00
D2394	Resin based composite – 4/more surf., posterior.-primary permanent	$ 87.00 $ 87.00
D2710	Crown, reinforced resin based, indirect	$ 235.00
D2721	Crown, resin base metal	$ 150.00
D2750	Crown, porcelain, high noble	$ 318.00
D2751	Crown, porcelain base metal	$ 318.00
D2752	Crown, porcelain, noble metal	$ 318.00
D2790	Crown, full cast, high noble	$ 300.00
D2791	Crown, full cast base metal	$ 300.00
D2792	Crown, full cast, noble metal	$ 300.00
D2920	Recement crowns	$ 31.00
D2930	Prefab stainless steel primary	$ 85.00
D2931	Prefab stainless steel permanent	$ 90.00
D2932	Prefab resin	$ 95.00
D2940	Sedative filling	$ 30.00
D2950	Core buildup – up to 2 pins, not used when procedure involves only filler	$ 71.00
D2951	Pin retention	$ 17.00
D2954	Prefabricated post and core	$ 80.00
D2955	Post removal	$ 70.00
D2980	Crown repair	$ 60.00
D2999	Unspecified restorative proc	MP
D3110	Pulp cap – direct	$ 20.00
D3220	Therapeutic pulpotomy	$ 50.00
D3221	Pulpal debrid., not 1st stage of root canal or same day as endo	$ 50.00
D3310	Root canal – anterior	$ 210.00
D3320	Root canal – bicuspid	$ 270.00
D3330	Root canal – molar	$ 315.00
D3346	Re-treat root canal - anterior	$ 210.00
D3347	Re-treat root canal – bicuspid	$ 270.00
D3348	Re-treat root canal – molar	$ 315.00
D3410	Apicoectomy /periradicular ant	$ 200.00
D3421	Apicoectomy/periradicular bicusp	$ 200.00
D3425	Apicoectomy/periradicular molar	$ 200.00
D3426	Apicoectomy/periradicular – root	$ 70.00
D3430	Retrograde filling	$ 63.00
D3999	Unspecified endodontic procedure	MP
D4210	Gingivectomy – 4 or more contiguous teeth in quadrant	$ 160.00
D4211	Gingivectomy - 1 to 3 teeth in quadrant	$ 106.00
D4320	Prov splinting intracoronal	$ 103.00

D4321	Prov splinting extracoronal	$ 91.00
D4341	Periodontal scaling/root planing, 4 or more contiguous teeth per quadrant. therapeutic, not prophy	$ 68.00
D4342	Periodontal scaling & root planing, 1-3 teeth	$ 68.00
D4355	Full mouth debridement	$ 60.00
D4910	Period maint procedures	$ 42.00
D4999	Unspecified periodontal proc	MP
D5110	Dentures, complete upper	$ 470.00
D5120	Dentures comp lower	$ 470.00
D5130	Dentures immediate upper	$ 490.00
D5140	Dentures immediate lower	$ 490.00
D5211	Part dent - upper – resin	$ 295.00
D5212	Part dent - lower – resin	$ 295.00
D5213	Part dent - upper - cast metal	$ 500.00
D5214	Part dent - lower - cast metal	$ 500.00
D5410	Denture adj complete upper	$ 20.00
D5411	Denture adj complete lower	$ 25.00
D5421	Part denture adj – upper	$ 26.00
D5422	Part denture adj – lower	$ 24.00
D5510	Repair broken complete denture	$ 56.00
D5520	Replace miss or broken teeth	$ 43.00
D5610	Repair resin base	$ 50.00
D5620	Repair cast framework	$ 82.00
D5630	Repair or replace clasp	$ 64.00
D5640	Replace broken teeth (maximum 5)	$ 42.00
D5650	Add tooth /existing partial	$ 55.00
D5660	Add clasp /existing partial	$ 70.00
D5670	Replace all teeth and acrylic on cast metal framework – maxil. (repair to partial denture)	MP
D5671	Replace all teeth and acrylic on cast metal framework – mandib.(repair to partial denture)	MP
D5730	Reline complete upper – chairside	$ 88.00
D5731	Reline complete lower – chairside	$ 91.00
D5740	Reline upper partial – chairside	$ 101.00
D5741	Reline lower partial – chairside	$ 64.00
D5750	Reline complete upper – lab	$ 128.00
D5751	Reline complete lower – lab	$ 128.00
D5760	Reline upper partial - lab	$ 91.00
D5761	Reline lower partial - lab	$ 105.00
D5850	Tissue conditioning - upper	$ 42.00
D5851	Tissue conditioning – lower	$ 34.00
D5899	Unspec remov prosth proc	MP
D5931	Obturator surgical	MP
D5932	Obturator definitive	$ 510.00
D5933	Obturator mod	MP
D5934	Mandibular resection w/ flange	MP
D5935	Mandibular resection w/o flange	MP

D5936	Obturator interim	MP
D5951	Feeding aid	MP
D5952	Speech aid pediatric	MP
D5953	Speech aid adult	MP
D5954	Palatal augmentation	MP
D5955	Palatal lift	MP
D5958	Palatal lift interim	MP
D5959	Palatal lift mod	MP
D5960	Speech aid mod	MP
D5982	Surgical stent	$ 75.00
D5988	Surgical splint	MP
D5999	Unspecified maxillofacial pr	MP
D6930	Recement fixed partial	$ 42.00
D6980	Fixed partial repair	$ 95.00
D6999	Unspecified fixed prosthodontic	MP
D7111	Coronal remnants – deciduous tooth	$ 43.00
D7140	Extraction, erupted tooth or exposed root; routine removal	$ 43.00
D7210	Surgical removal erupted tooth	$ 74.00
D7220	Removal of impacted tooth	$ 96.00
D7230	Surgical extraction – impact	$ 112.00
D7240	Surgical extraction – impact	$ 145.00
D7241	Surgical extraction - impact	$ 146.00
D7250	Surgical extraction - root	$ 80.00
D7270	Tooth reimplantation	$ 66.00
D7280	Surg exposure of unerupted tooth, for orthodontics only	$ 150.00
D7281	Surg exposure of impacted	$ 80.00
D7286	Biopsy oral tissue, soft, surgical removal of specimen	$ 80.00
D7287	Cytology sample collect.–mild scraping mucosa	$ 80.00
D7320	Alveoloplasty without extract, per quadrant	$ 88.00
D7471	Removal lateral exostosis, max. or mand.	$ 158.00
D7510	Incision and drain, including periodont. origins	$ 43.00
D7910	Suture of small wound	$ 22.00
D7960	Frenulectomy	$ 100.00
D7970	Excision hyperplastic tissue	$ 77.00
D7971	Excision of pericoronal gingiva	$ 40.00
D7999	Unspecified dental surgery	MP
D8010	Limited ortho primary	$ 210.00
D8020	Limited ortho transition	$ 240.00
D8030	Limited ortho adolescent	$ 280.00
D8040	Limited ortho adult dentition	$ 300.00
D8070	Comprehensive ortho transition	$ 850.00
D8080	Comprehensive ortho adolescent	$ 1,000.00
D8090	Comprehensive ortho adult	$ 1,250.00
D8210	Removable appliance therapy	$ 200.00
D8220	Fixed appliance therapy	$ 300.00
D8670	Adjustments monthly	$ 84.00

D8680	Retainers (both)	$ 150.00
D8691	Repair ortho appliance	$ 50.00
D8999	Unspecified ortho	MP
D9110	Emergency palliative treatment	$ 35.00
D9220	Deep sedation/general anes. 1st 30 min.	$ 98.00
D9221	Deep sedation/general anes. each addit. 15 min	$ 38.00
D9230	Analgesia	$ 17.00
D9241	IV conscious sedation/anes. 1st 30 min – provider cert. required	$ 80.00
D9242	IV conscious sedation/anes. ea addit. 15 min	$ 30.00
D9310	Consult. requested by other dentist or physician, prob. specific	$ 30.00
D9410	House/extended care facility call	$ 30.00
D9420	Hospital calls	$ 93.00
D9430	Office visit - observation	$ 18.00
D9440	Office visit after hrs	$ 35.00
D9920	Difficult behavior management	$ 22.00
D9930	Treatment of complication	$ 20.00
D9940	Occlusal guards	$ 145.00
D9951	Occlusal adjustment-limited	$ 20.00
D9952	Occlusal adjustment-complete	$ 140.00
D9999	Unspecified adjunctive procedure	MP

MP refers to manually priced claims. Manually priced claims will be managed through the Division of Medicaid prior to rendering the service. Additionally, all prior-authorization requirements for crowns and orthodontics remain applicable.

April 29, 2003

MEDICAID INFORMATION RELEASE #2003-25 – CORRECTED VERSION

TO: PHARMACY PROVIDERS

FROM: Paul Swatsenbarg, Deputy Administrator, Division of Medicaid

SUBJECT: BILLING PHARMACY CLAIMS WITH OTHER INSURANCE COVERAGE

On April 15, 2003 an incorrect version of Information Release 2003-25 was mailed out. This document replaces the previous document.

Effective May 5, 2003, the Idaho Medicaid program requires that, for clients with other insurance pharmacy coverage, drug claims must be billed to the client's other insurance(s) prior to submission to Idaho Medicaid for payment. If a client has other insurance you will get rejection code 41- "Submit bill to other processor or primary payor" at point of service (POS).

In order to submit an electronic POS claim for a client with other insurance, the following information is required:

- **Coverage code:**
  - 0 Not Specified
  - 1 No other coverage identified
  - 2 Other coverage exists-payment collected (use this value if partial payment was made by other insurance).
  - 3 Other coverage exists-this claim not covered
  - 4 Other coverage exists-payment not collected
  - 5 Managed care plan denial
  - 6 Other coverage denied-not a participating provider
  - 7 Other coverage exists-not in effect at the time of service
  - 8 Claim is a billing for co-pay

- **Carrier Code:** The National Electronic Insurance Clearinghouse (NEIC) code identifying the Other Insurance Carrier. Use a valid code for the client's other carrier. Carrier code is typically listed on a client's insurance card. The carrier codes listed below and in the Provider Electronic Solutions (PES) software is not a comprehensive list. Please contact EDS for additional NEIC numbers that are accepted and used.

  - 10 Utah-Idaho Teamsters Health & Welfare
  - 11 Railroad Employee
  - 12 Blue Shield of Idaho (Regence)
  - 14 Mail Handlers
  - 20 Palmetto Government Benefit Adm.
  - 25 Oregon Life and Health
  - 37 Bankers Life & Casualty
  - 38 Regence Life and Health
  - 39 Blue Cross of Idaho
  - 41 Blue Cross of Washington/Alaska
  - 51 Union Bankers Insurance
  - 53 Deseret Mutual Benefit
  - 58 First Health
  - 59 TPM/Timber Product Management
  - 62 N A L C Health Benefit
  - 63 Lamb-Weston GR Claim
  - 68 Globe Life & Accident
  - 70 I E C/Ameri Ben solutions
  - 74 Administration Service

77	Medical Services Corporation (MSC)
79	Mutual of Omaha
83	Physicians Mutual
102	GEHA
124	First Health
148	Iowa Benefits
158	Blue Cross of California
160	Great West Life
162	Lamb Weston
173	Group Health Northwest
192	Blue Cross Blue Shield of Utah
194	Group Health Northwest
197	Jensen Administrative Services
213	Blue Cross of Idaho
221	Wal-Mart Benefits
228	Cigna
246	Highmark B C B S of Pennsylvania
253	Boise Cascade Insurance
266	Cigna
296	Health Med/Qualmed
302	United Health Care
303	First Health
307	Washington-Idaho Operating Engineer
310	First Health HP Employee
314	Blue Cross of Pennsylvania
337	HMO Blue
347	United Health Care
364	Mega Life & Health
367	United Health Care
380	Aetna/Prudential
433	United Health Care
437	AARP
447	AETNA
485	Mega Life & Health
489	Combined Insurance
504	Educators Mutual
555	AETNA
577	Lincoln National
597	Principal Financial/JR Simplot
615	I H C
639	Retail Clerks Trust
751	CIGNA
752	Heller Associates
813	Principal Financial
821	First Health RX (ALTA RX)
1110	Benesight/Third Party Administrator
MEDA	Medicare Northwest
MEDB	Medicare Cigna
RRA	United Health Care
RRB	United Health Care

- **Coverage Type:**
  - 01 Primary
  - 02 Secondary
  - 03 Tertiary
- **Amount paid by other insurance** (include dollars and cents)
- **Other insurance paid date** (MM/DD/CCYY)
- **Other insurance reject code** (indicating the reason the other insurance denied payment (if applicable). **Do not use a reject code if the other insurance made a partial payment.**

  - 60 Product/service not covered for patient age
  - 61 Product/service not covered for patient gender
  - 65 Patient not covered
  - 67 Filled before coverage effective
  - 68 Filled after coverage expired
  - 69 Filled after coverage terminated
  - 70 Product/service not covered
  - 73 Refills are not covered
  - 76 Plan limitation exceeded
  - 78 Cost exceeds maximum
  - AG Days supply limitations for product/service
  - M1 Patient not covered in this aid category
  - M2 Recipient locked in
  - M4 Prescription/service reference number/time limit exceeded
  - PA PA exhausted/not renewable
  - P5 Coupon expired
  - RN Plan limit exceeded on intended partial bill values

If you have any questions regarding this information, please call EDS at 383-4310 in the Boise area or toll-free 1-800-685-3757.

Thank you for participating in the Medicaid program.

PS/ea

May 1, 2003

Dear Medicaid Client:

Re: New Pharmacy Procedure Starting May 5, 2003

If you have private health insurance and Medicaid, you will have to show your private insurance card **and** your Medicaid card to your pharmacist before your prescription will be filled. This information will help your pharmacist bill your other insurance before he/she bills Medicaid. If you have Medicaid only, you may disregard this notice.

This change is being made because of Federal regulations. If you have any questions, please contact the Medicaid Customer Service line at 334-5795 or toll-free 1-800-378-3385.

Sincerely,

Paul Swatsenbarg
Deputy Administrator

April 1, 2003

MEDICAID INFORMATION RELEASE MA#2003-26

TO: PHARMACY PROVIDERS

FROM: Paul Swatsenbarg, Deputy Administrator

SUBJECT: CLAIM SUBMISSION FOR COMPOUND DRUGS

Effective May 5, 2003, the Idaho Medicaid Program will begin accepting pharmacy claims using NCPDP Version 5.1 format for electronic drug claims. This format supports electronic billing of compound drug claims. In order to submit an electronic point of service pharmacy claim for a compound drug, the following information is required:

- **A compound indicator value of 2** designates the claim as a compound drug claim combining two or more ingredients
- **A submission clarification code equal to 8** indicates if one or more of the ingredients billed is invalid and you want to be paid for the valid ingredients. This allows the claim to post a zero payment to the invalid ingredient(s) and process the rest of the valid ingredients to pay at the applicable allowed amount.
- **A dosage form for the final compound product** (form of final compound, not the ingredients) using the following codes:

Blank	Not Specified	11	Solution
01	Capsule	12	Suspension
02	Ointment	13	Lotion
03	Cream	14	Shampoo
04	Suppository	15	Elixir
05	Powder	16	Syrup
06	Emulsion	17	Lozenge
07	Liquid	18	Enema
10	Tablet		

- **A dispensing unit indicator for the final compound product**:

1. Each
2. Grams
3. Milliliters

- **A dosage route of administration for the final compound product**:

0	Not Specified	12	Other/Miscellaneous
1	Buccal	13	Otic
2	Dental	14	Perfusion
3	Inhalation	15	Rectal
4	Injection	16	Syrup
5	Intraperitoneal	17	Topical
6	Irrigation	18	Transdermal
7	Mouth/Throat	19	Translingual
8	Mucous Membrane	20	Urethreal
9	Nasal	21	Vaginal
10	Ophthalmic	22	Enteral
11	Oral		

- **Ingredient National Drug Code (NDC) for each ingredient**
- **Ingredient quantity for each ingredient**
- **Ingredient cost for each ingredient** (If left blank or submitted with $0.00 cost, no payment will be made for that ingredient).

If you have any billing questions, please contact EDS at 383-4310 in the Boise area or toll-free 1-800-685-3757. Policy questions may be directed to the Pharmacy Unit at (208) 364-1829.

Your participation in the Medicaid program is appreciated.

PS/ea

May 1, 2003

MEDICAID INFORMATION RELEASE 2003-27

TO: PHYSICIANS, OSTEOPATHS, DENTISTS, MID-LEVEL PRACTITIONERS, PHARMACISTS, AND ALL OTHER PRESCRIBING PROVIDERS

FROM: Paul Swatsenbarg, Deputy Administrator, Division of Medicaid

SUBJECT: VOLUNTARY PREFERRED DRUG INITIATIVE - UPDATE

Effective **May 1, 2003**, Medicaid is requesting all providers prescribe the preferred agents within the following classes of medications:

Drug Class	Preferred Agent(s)
Urinary Incontinence Agents	Oxybutynin – Various Generics
Skeletal Muscle Relaxants	Baclofen – Various Generics Carisoprodol – Various Generics Cyclobenzaprine – Various Generics

Information Release 2003-12 effective **March 17, 2003** Medicaid requested all providers to prescribe the preferred agents in three specific classes. When ever possible, please continue to prescribe the preferred agents in the drug classes below in addition to the two additional drug classes:

Drug Class	Preferred Agent(s)
Long Acting Opioids	Methadone HCL –Dolophine® - Methadose® - Methadone HCL generics Fentanyl Transdermal System (Duragesic®) Levorphanol - Levo-Dromoran® - Levorphanol generic Long Acting Morphine Sulfate -Kadian® -Oramorph SR® -LA Morphine Sulfate generic
Triptans Serotonin (5HT $_{1B/1D}$) Agonists	Rizatriptan (Maxalt®,Maxalt-MLT®)

All agents in the Proton Pump Inhibitor class require prior authorization. Effective March 17, 2003, the Department has designated the Pantoprazole (Protonix ®) as the preferred agent for the Proton Pump Inhibitor drug class. When prior authorization has been approved for a Proton Pump Inhibitor the department is requesting that the preferred agent be prescribed whenever possible. Existing prior authorization guidelines and requirements for all agents, including Protonix ® will remain in effect.

Drug Class	Preferred Agent(s)
PPIs Proton Pump Inhibitors	Pantoprazole (Protonix®)

Listed below is an on-line link to clinical information outlining the therapeutic evaluation used to determine the preferred agents within the drug classes.

http://www2.state.id.us/dhw/medicaid/providers/pharmacy.htm

Then click on Preferred Drug Initiative.

Prescribing of the preferred agent is a voluntary compliance request. The Department is requesting providers, when appropriate, prescribe the preferred agents within these drug classes. The ability to maintain a voluntary approach to the Preferred Drug Initiative will depend upon prescribers' willingness to use, whenever possible, the preferred medications in a therapeutic class.

The Medic-Aide newsletter will contain more information and updates to the Preferred Drug Initiative. If you have any questions regarding this program change, you may contact the Medicaid Customer Service team at 334-5795 or 1-800-378-3385.

Please post this information for the convenience of the prescribing provider in an easily visible location.

Drug Class	Preferred Agent(s)
Urinary Incontinence Agents	Oxybutynin – Various Generics
Skeletal Muscle Relaxants	Baclofen - Various Generics Carisoprodol – Various Generics Cyclobenzaprine - Various Generics
Long Acting Opioids	Methadone HCL - Dolophine® - Methadose® - Methadone HCL generics Fentanyl Transdermal System (Duragesic®) Levorphanol - Levo-Dromoran® - Levorphanol generic Long Acting Morphine Sulfate -Kadian® -Oramorph SR® -LA Morphine Sulfate generic
Triptans *Serotonin (5HT 1B/1D) Agonists*	Rizatriptan (Maxalt®,Maxalt-MLT®)
PPIs *Proton Pump Inhibitors*	Pantoprazole (Protonix®)

April 15, 2003

MEDICAID INFORMATION RELEASE # 2003-28

T0: ALL TARGETED CASE MANAGEMENT SERVICE PROVIDERS

FROM: Paul Swatsenbarg, Deputy Administrator, Division of Medicaid

Subject: CRISIS CASE MANAGEMENT SERVICES FOR PERSONS WITH A MENTAL ILLNESS

The Department recently met with representatives of the Case Management Association of Idaho and the Mental Health Providers Association of Idaho to discuss the need for the provision of crisis case management. Through this collaborative effort, the group was able to develop language and criteria for the provision of crisis case management services to adults with severe and persistent mental illness. This new language and criteria will appear in an amendment to temporary rule that will be published in the May 7th edition of the Idaho Administrative Bulletin.

Effective April 28, 2003 amended temporary rules will allow mental health case managers to deliver up to four (4) additional hours of ongoing case management (procedure code 8196A), without a required prior authorization, to address crisis case management needs of service participants.

By definition, crisis case management services are linking, coordinating and advocacy services provided to assist a recipient with accessing emergency community resources in order to resolve a crisis. Crisis case management services do not include crisis counseling, transportation to emergency service providers, direct skills building services, or encouragement of independence as identified in IDAPA 16.03.09.478.04.

The crisis must be precipitated by an unanticipated event, circumstance, or life situation that places a recipient at risk of any of the following: *hospitalization; incarceration; becoming homeless; losing employment or major source of income; or physical harm to self or others, including family altercation or psychiatric relapse.*

Beginning April 28, 2003, the Department or its designee may authorize additional crisis case management services. To be eligible for additional crisis case management services, the recipient must have already received four (4) hours of ongoing case management (current limitation) and four (4) hours of crisis case management. The Department or its designee may authorize additional hours for crisis case management if a recipient still has severe or prolonged crisis case management needs and meets all of the following criteria:

1. The service recipient is at imminent risk (within fourteen (14) days) of hospitalization or institutionalization, including nursing home; and
2. The service recipient is experiencing symptoms of psychiatric decompensation; and
3. The service recipient has already received the maximum number of monthly hours of ongoing case management and crisis case management; and
4. No other crisis assistance services are available to the recipient under other Medicaid mental health option services, including Psychosocial Rehabilitation Services (PSR).

Also effective April 28, 2003, Medicaid's Automated Information System (AIM) will allow automatic claims processing of crisis case management services that do not require Department authorization. The Department will retrospectively review claims for crisis case management reimbursement to ensure appropriateness of the services and will recoup monies paid for unsubstantiated claims.

The Department will offer 1.5 hour video-conference training on crisis case management to Targeted Case Management providers on **May 6, 2003** from **2:00 -3:30 PM MST or 1:00 -2:30 PM PST.** Locations for the video-conference are:

DHW Region 1: *U of I Extension Office – Coeur d'Alene*
1000 West Hubbard
Room 112

DHW Region 2: *LCSC – Lewiston*
Sam Glenn Complex
Room 50
Map: http://www.lcsc.edu/welcome/map.htm

DHW Region 3 & 4: *Joe R. Williams Bldg. – Boise*
700 W. State
East Conference Room

DHW Region 5: *CSI – Twin Falls*
Aspen Building
Room 195
Map: http://www.csi.edu/images_/campusMap.jpg

DHW Region 6: *ISU – Pocatello*
Library Media Center
Room B35
Map http://www.isu.edu/isutour/isumap.html

DHW Region 7: *EITC - Idaho Falls*
John E. Christofforson Building
Room 371
Map: http://www.eitc.edu/aboutus/campusmap.cfm

For those unable to attend the training, a videotaped copy will be available for checkout from the Department within thirty (30) days of the training.

Additional authorization guidelines have been included with this notice. Please see enclosed:

"*Process For Authorization Of Additional Crisis Case Management Hours Under Targeted Case Management (TCM) For The Mentally Ill*" - Instructions on how to request authorization for additional case management hours.

"Request For Additional Crisis Case Management Hours" - A sample request form that must be completed and sent to DHW for review and decision before additional crisis management hours may be approved.

Mental health case management providers are encouraged to inform case management service recipients of the changes concerning crisis case management services.

For specific questions regarding DHW authorization of crisis case management services beyond four (4) hours, please contact Shannon Froehlich at (208) 364-1903. If you have questions regarding the information in this notice, please contact Carolyn in Medicaid Customer Service at (208) 334-5795. Thank you for your continued participation in the Idaho Medicaid Program.

PROCESS FOR AUTHORIZATION OF ADDITIONAL CRISIS CM HOURS UNDER TARGETED CASE MANAGEMENT (TCM) FOR THE MENTALLY ILL

April 28, 2003

Request for Additional Crisis Case Management Hours

Additional community crisis case management (CM) hours are requested in order to facilitate access to emergency community resources, by linking/coordinating, and/or advocating for services. The limitation (cap) of four (4) hours of ongoing case management per month will remain in place. If the participant experiences a crisis as defined in IDAPA 16.03.09.478.03 and the case manager has already provided four (4) hours of non-crisis case management in a calendar month, the CM may provide and bill for up to four (4) additional hours of on-going case management services during that same calendar month to address crisis case management needs. Any request for additional ongoing case management hours to address crisis case management needs, above the four (4) hours per month, will require authorization by the central office care manager and must meet criteria set forth in IDAPA 16.03.09.478.03 & 16.03.09.483.07.

Process to Request Additional Crisis Case Management Hours

1. The TCM Case Manager (Agency) completes the form "Request for Additional Crisis Case Management Hours".
2. Case Manager E-mails or faxes the completed form(s) to Central Office, Behavioral Health Care Management Unit, which includes:
    - Request for Additional Crisis CM Hours
    - Participant's TCMMI Assessment and Treatment Plan
    - Applicable Progress Notes
3. Central Office Care Manager will complete the Authorization/Denial form for Additional Crisis CM Hours and will E-mail or fax back a decision to case manager (Agency) within forty-eight (48) business day hours of the date of receipt of the "Request for Additional Crisis Case Management Hours".
4. If criteria for authorization of crisis case management services are met, then the Care Manager will enter an electronic service authorization into Medicaid's Automated Information System (AIM).
5. The TCM Agency may then bill for services authorized.

Informal Dispute Resolution Process

1. The TCM Agency contacts the central office Care Manager and requests an Administrative Review of the Care Manager's authorization decision.
2. The Care Management Bureau conducts an Administrative Review of the authorization decision within 72 business day hours.
3. The Medicaid Behavioral Health Manager informs the TCM Agency of the results of the Administrative Review.
4. The Medicaid Behavioral Health Manager and/or the central office Care Manager may or may not amend the original authorization decision depending on the outcome of the Administrative Review.

Formal Appeal Process

You may request an appeal by writing to:

Sherri Kovach
Administrative Procedures Coordinator
450 W. State Street, 10th Floor
Box 83720
Boise, Idaho 83720-0036

Division of Medicaid
Behavioral Health Care Management Unit

REQUEST FOR ADDITIONAL CRISIS CASE MANAGEMENT HOURS

Additional Community Crisis Case Management hours are requested in order to facilitate access to emergency community resources, by linking/coordinating, and/or advocating for services. To be eligible for additional crisis case management services, the service recipient must have already received four (4) hours of non-crisis case management and four (4) hours of crisis case management.

Participant Name:
Medicaid Number:
From Case Manager:

Participant must meet all of the following criteria:

- **Imminent risk (within 14 days) of hospitalization or institutionalization; and**
- **Experiencing symptoms of psychiatric decompensation; and**
- **Has received the maximum number of monthly hours of ongoing case management and crisis case management; and**
- **No other crisis assistance services are available under other Medicaid mental health option services (including) Psychosocial Rehabilitation Services)**

Crisis must be precipitated by an unanticipated event, circumstance, or life situation that places the participant at risk of: (check all that apply)

☐ Hospitalization	☐ Losing employment or major source of income
☐ Incarceration	☐ Physical harm to self or others
☐ Becoming homeless	(family altercation or psychiatric relapse)

Please document the following information in detail, attach the case management assessment & treatment plan, and any applicable progress notes.

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1. Presenting Problem:

A. Date crisis began:

B. Describe the crisis, include the unanticipated event or circumstance that lead to the crisis**.**

C. What symptoms of psychiatric decomposition are present?

2. Crisis Response History:

MONTH TO DATE TOTALS: Ongoing Case Management: _____ Crisis Case Management:_____

A. What linking, coordination, or advocacy services have already been provided to resolve this crisis? (Include the number of ongoing case management and crisis case management units or hours already provided during this calendar month).

B. What other crisis assistance services are available to the recipient under other Medicaid mental health option services (e.g. Psychosocial Rehabilitation Services)?

3. Crisis Resolution Plan

A. Action Plan: What is your agency's response to resolving the crisis? (Be specific and identify what linking, coordinating, or advocacy services will be provided)

B. How does this intervention promote the health and safety of the recipient or prevent hospitalization/incarceration/out of home placement?

Participant Name:

Agency Name:
Phone Number:
Fax Number:
E-Mail Address:

April 11, 2003

MEDICAID INFORMATION RELEASE 2003-29

TO: **ALL GENERAL ACUTE HOSPITALS, CHILDREN'S HOSPITALS AND INDIAN HEALTH SERVICE HOSPITALS**

FROM: Paul Swatsenbarg Deputy Administrator, Division Of Medicaid

SUBJECT: **NON-CITIZEN EMERGENCY MEDICAL DOCUMENTATION FOR LABOR AND DELIVERY AND OTHER EMERGENCY MEDICAL REQUESTS**

Beginning April 1, 2003, the process for approving labor and delivery for Non-Citizen Emergency Medical services has changed.

Labor and Delivery Services

Requests for payment of C-Sections and vaginal deliveries for non-citizens require review by the Department. Consideration for coverage for non-citizens requires submission of the following documentation:

1. Admission record (including date and time of admission)
2. Discharge summary (including date and time of discharge)
3. Doctor's delivery notes

Other Medical Services

All other requests for emergency medical services for non-citizens also require review. The dates of service should be included with the following documentation:

1. History and physical
2. Admission and discharge summaries
3. Doctor's orders and doctor's progress notes
4. Emergency room report

Providers should submit the request for consideration of payment with all the required documentation to the local Self-Reliance Services (SRS) office. Requests will be reviewed by the local SRS and the Medicaid Care Management Bureau. The local SRS office will notify each non-citizen applicant of the determination.

If the request for review is initiated by the hospital, the SRS will notify the hospital provider of the determination.

If you have questions regarding the information in this notice, please contact Carolyn at (208) 364-1827. Thank you for your continued participation in the Idaho Medicaid Program.

PS/cbp

April 14, 2003

MEDICAID INFORMATION RELEASE #2003-31

TO: IDAHO MEDICAID PROVIDERS

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: HIPAA PRIVACY – COVERED ENTITIES

The new Federal Regulations called HIPAA (Health Insurance Portability and Accountability Act) allow the use and disclosure of identifying or protected health information between "covered entities" to provide treatment, payment or health care operations (45 CFR Part 164.506).

According to Idaho rule, Department employees and contractors may use and disclose records as necessary to perform normal business functions, including health treatment, audit and quality improvement, investigation of fraud and abuse, establishment of overpayments and recoupment, public health, or other functions authorized by law. Information will be made available to state and federal auditors and compliance monitors (IDAPA 16.05.01.100.05).

By way of clarification, written authorization from the patient is not required for covered entities to disclose identifying or protected health information to Department staff and Medicaid's Business Associate Contractors when there is a need-to-know for them to do their jobs.

Department Staff

Department staff performs a number of services necessary to provide clients with treatment, payment and normal health care operations including:

- Prior authorizations for services such as transportation (non-emergency medical), medical equipment, certain medicines and most brand name drugs when generics are available, physical therapy, certain vision services, and other services.
- Audits, investigations, and inspections in compliance with state and federal regulations.
- Health oversight activities such as monitoring the Medicaid program for fraud and abuse of services.

Medicaid's Business Associate Contractors

The Department has contracted with several organizations to conduct some of our health care operations. Agreements with the following business associate contractors authorize them to conduct Medicaid's health care operations on our behalf:

- EDS – claims payments
- QUALIS Health – utilization and case management
- Thomas Young, MD – case management
- Myers & Stauffer – auditing services
- SWEEP – Medicaid's supplier for glasses (frames and lenses)
- Thomas Bruck, DDS and A. Riley Cutler, DDS – prior authorization of dental services
- ISU-DUR – drug utilization review
- Public Consulting Group – third party recovery

Your cooperation and assistance in sharing appropriate protected health information with Department staff and their business associate contractors will enable us to continue the administrative and operational procedures necessary to provide services and benefits to our clients while complying with applicable HIPAA regulations.

If you have questions, please contact Arlee Coppinger at (208) 334-5747.

KA/dy

April 30, 2003

MEDICAID INFORMATION RELEASE 2003-32

TO: NON-HOSPITAL-BASED AIR AMBULANCE SERVICE PROVIDERS

FROM: Paul Swatsenbarg, Deputy Administrator

SUBJECT: CHANGE IN NON-HOSPITAL-BASED AIR AMBULANCE REIMBURSEMENT METHODOLOGY

Idaho Medicaid is changing the current non-hospital-based air ambulance reimbursement methodology and rates to align more closely with Medicare's bundled reimbursement methodology for air ambulance services. The following changes to non-hospital-based air ambulance reimbursement are effective for dates-of-service on or after **May 1, 2003.**

- Supplies and medications will be included within the bundled rates and will no longer be covered as separately billable services/items.
- HCPCS codes must be used for fixed wing and rotary air ambulance services. In addition to the base rate, mileage must be billed separately with appropriate HCPCS codes.
- These are the new Medicaid covered codes and reimbursement rates for claims with dates of service on or after 5/1/2003. These codes are HIPAA compliant.

HCPCS	Description	Reimbursement
A0430	Fixed wing – base rate	$ 773.33
A0435	Fixed wing – mileage rate (per mile)	$ 6.57
A0431	Rotary wing – base rate	$ 899.11
A0436	Rotary wing – mileage rate (per mile)	$ 17.51

For retrospective review of emergency ambulance services and prior authorization of non-emergency ambulance services, please contact the EMS Bureau, Review Unit at (208) 334-2484 or toll-free (800) 362-7648. If you have questions regarding the information in this notice, please contact Colleen Osborn (208) 364-1923. Thank you for your continued participation in the Idaho Medicaid Program.

PS/af/co

EDS
P.O. Box 23
Boise Idaho 83707

IDAHO DEPARTMENT OF HEALTH & WELFARE

Attention: Business Office

Submitting split claims for the fiscal year end

When billing for dates of service that span a fiscal year end there are a few important steps that must be taken:

1. Write the words 'split claim' clearly across the top of the claim form.

2. Use the EOMB (Explanation of Medicare Benefits) to submit two claims if it spans the fiscal year end.

Do **not** change the dates on the EOMB itself; just note on each claim that it is a split claim. If it is not clear that a claim is a split claim, it will be returned because the dates/dollar amounts on the EOMB do not match the claim.

Example: the EOMB spans 7/1/03 to 7/30/03 and the fiscal year ends on 7/15/03. The first claim will span from 7/1/03 to 7/15/03 with a copy of the EOMB attached. The second claim will span 7/16/03 to 7/30/03, also with a copy of the EOMB attached.

3. Submit only one claim if the total amount Medicaid owes is all deductible. The total deductible amount is paid on the first date of service only. It is a lump payment and it does not matter how many days are on the EOMB. Use the last dates of service in the fiscal year and attach a copy of the EOMB. Write 'split claim' across the top of the claim form. A second claim form is not needed for the remaining dates of service in the new fiscal year since the entire claim will have been paid in full. This applies only to Medicare inpatient claims.

If you have any payment issues with split claims, contact your Provider Relations Consultant or call MAVIS and ask for *AGENT*: (800) 685-3757 or (208) 383-4310.

Submitted by EDS

MedicAide is the monthly informational newsletter for Idaho Medicaid providers.

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